“PIZZAS ARE DELIVERED, BABIES ARE BORN”: THOUGHTS AND OPINIONS ABOUT BIRTH AND THE MATERNITY CARE SYSTEM IN COLORADO

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B.S., University of Wisconsin-La Crosse, 2011

A thesis submitted to the

Faculty of the Graduate School of the

University of Colorado in partial fulfillment

of the requirements for the degree of

Master of Arts

Anthropology

2013

This thesis for the Master of Arts degree by

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April 15, 2013

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"Pizzas are Delivered, Babies are Born": Thoughts and Opinions about Birth and the Maternity Care System in Colorado

Thesis directed by Assistant Professor Marty Otanez.

ABSTRACT

There is a current crisis in the United States in regards to maternity care standards and accessibility. Roughly 4.3 million births happen each year in this country, and the approximately 99% of those births occur in hospitals. Whereas at the beginning of the 20th century, only 95% of births took place at home, by the beginning of the 21st century only 1% of births took place at home. U.S. society changed from viewing birth as a physiological process that happens spontaneously and effectively to a legal, medical event. There is supporting evidence that homebirths are just as safe as hospital births, yet a very small percentage of women opt to use a midwife, have a homebirth, or give birth at a birthing center in favor of going to a hospital for delivery. The purpose of this study is to better understand how pregnant women choose a birthing attendant, location, and delivery method. The research is grounded in practice theory as articulated by Pierre Bourdieu and Anthony Giddens. Snowball sampling was used to recruit nine pregnant women from various locations in Colorado. Participants were interviewed and their responses were transcribed, coded, and analyzed to help with the identification of the barriers keeping women from utilizing homebirth, a safe, affordable, and natural method of delivery.

The form and content of this abstract are approved. I recommend its publication.

Approved: Marty Otanez

ACKNOWLEDGMENTS

I would not be where I am today if my undergraduate advisor, Christine Hippert, hadn't introduced me to the world of maternity care. She gave me the book that has inspired this research project, and I want to thank her for her continuous guidance and support. Indra Lusero has also been a huge inspiration during this research endeavor. Her passion about birth and hopefulness of the future are truly an inspiration.

It must be said that the training that I have been given during my experience at UCD has allowed me to take on a project of this magnitude, and the completion of this thesis could not have occurred without the guidance and support of the Anthropology faculty. I would like to thank the entire faculty who has greatly influenced me, my outlook on the world, and my approaches in Anthropology. Marty Otanez, my thesis chair and advisor, has spent numerous hours talking with me about this project. He pushed me to be creative, and helped me get the most out of this experience. I wish to thank my committee members Jean Scandlyn and Steve Koester for their encouragement, comments, and suggestions; my project is better because of them.

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CHAPTER I

INTRODUCTION: LABOR, DELIVERY, AND DECISIONS

Giving birth is one of the human universals shared among women, and over time, people have developed many different strategies to ensure successful births. Every culture has its own "way of conceptualizing birth" which serves as "the single most powerful indicator of the general shape of its birthing system" (Jordan 1993:48). When looking from a global perspective, we consistently see that the majority of women in the world give birth at their home, aided by their mothers, sisters, aunts, or midwives (Jordan 1993:122-123). People opting for this method of delivery tend to view birth as a "normal physiological process that happens spontaneously and effectively" (Lusero 2010:1). Society in the United States differs from this approach to delivery and instead favors a more technological approach to this natural process.

Like many industrialized countries in the world, the United States culturally accepted a technocratic approach to birth (Davis-Floyd 2003:45-46). In the 20th century, modernization and development in the U.S. led to "massive modifications of the traditional way of life" (Jordan 1993:128). As the human body began to be seen as a machine that needed to be and could be fixed by highly trained professionals, birthing in the U.S. had to change. The country experienced a massive shift from home to hospital when it comes to birth location. This shift brought women the comfort of technology, trained physicians, and medicine, but it also came with an increase in cost and invasive procedures, and a belief that giving birth at a hospital is the best option for delivery. This new "locally shared view of childbirth" is what led people in the U.S. to "have similar ideas regarding the course and management of birth" (Jordan 1993:48). The understanding of the birth process changed from being a natural and normal process to being a legal, medical event (Lusero 2010:1, Starr 1982). Delivering at hospitals with physicians also caused a shift in power to occur; women lose their decision-making power to hospital personnel

and physicians once admitted into hospitals (Jordan 1993:46). This loss of decision-making power is a reflection of the "changes in the structure of social organizations" (Starr 1982:161). Because the norm in this country has been to deliver babies in hospitals for over 100 years, viewing pregnant women as patients is well established in the habitus of many citizens (Jordan 1993:49).

Approximately 4.3 million births happen each year in the U.S., and roughly 99% of these births take place in a hospital (Sakala and Corry 2008:2). Childbirth in the U.S., like other physiological processes, is "culturally defined as belonging in the medical domain" (Jordan 1993:49). When compared to homebirths, hospital births have higher rates of infection, higher rates of invasive procedures, and very high cost. Despite these aspects, 84% of women believe that their hospital experience was "just fine" (Declercq et al.2006). The national average for cesarean sections is 32.9%, maternity care hospital charges amount to nearly $80 billion, and the drawbacks to procedures such as receiving an epidural are almost never mentioned to expectant mothers (Joyce et al. 2011:9, Lusero 2012:1, Childbirth Connection 2012). There is also a discrepancy when it comes to the level of education and prenatal care among women in the U.S. Poor women in this country do not have as much access to prenatal care and education classes as do women belonging to middle and upper socioeconomic brackets (Jordan 1993:57). These are only a few of the problems with the current maternity care system in the U.S., and for many citizens, these problems are not known.

As more research on the topic has been conducted, we have the evidence suggesting that low-risk births are just as safe at home as at a hospital, yet only a very small percentage of women opt to use a midwife, have a homebirth, or even give birth at a birthing center (Janssen et al. 2009:377). Based on national data collected by the Centers for Disease Control and

Prevention, it is evident that the majority of women still prefer giving birth at a hospital with a physician as opposed to at home with a midwife. Before change can occur in the maternity care system of the United States, we need to understand why women are choosing hospital births over other available options.

Current research has identified that the population most likely to use alternative or natural forms of delivery are White, middle class, educated women (Boucher et al. 2009:121). What is less known, however, is what specific factors led them to make that choice and what is keeping other women from leaving hospital births behind. The purpose of this study is to better understand the decision making process of pregnant women when it comes to choosing a birthing attendant, location, and delivery method. This study will help us identity influential factors when making decisions as well as the barriers keeping women from utilizing alternative safe, affordable, and natural methods of delivery. Once we know why and how women make the decisions they do about their delivery method and location, we can then identity the influencing factors and address them through knowledge dissemination and policy change in the state of Colorado.

This is an exploratory study to gather data for future studies on the subject. The information gathered in this study will be contribute to efforts hoping to improve maternity care in Colorado. Many birth advocates believe that women should be provided with family centered care and options for delivery that not only fit their values, but also promote physiologic birth and better outcomes (Lusero 2012:5). Ideally, maternity care in Colorado will shift and give priority to effective, safe, and cost effective paths of delivery while only using risky interventions for situations when all other measures are inadequate. This type of system would benefit mothers, babies, and purchasers (Sakala and Corry 2008:4). Utilizing the midwifery model of care is

beneficial because midwives "support women's rights to self-determination and encourage women to be active participants in decision-making processes" (Goodman 2007:611). Before policies or programs can be created and implemented, the acting structures and barriers must first be identified. We cannot begin crafting policy for improved maternity care if we do not understand how and why pregnant women make their decisions about birth.

Some of the particular topics that will be discussed and analyzed include: knowledge about options, family influence, and experience. These categories will allow for discussions leading to an early understanding of the important factors in the decision making process for pregnant women. Discussing birth location is essential because it will also indicate the resources that are available and the type of social interactions that will be experienced (Jordan 1993:67). Based on the participants' responses, we can then begin to move forward with implementing programs and policies that will help ensure that all women are educated about their options and are able to choose the method of delivery that is best for their pregnancy. Even when women give birth at a hospital, they should be given the opportunity to be informed about their available options before labor, and hospitals should adhere to a rigorous informed consent process (Sakala and Corry 2008:35). Birth advocates have a blueprint for the future, but those blueprints need supporting evidence that the changes are indeed what mothers want.

There is a current crisis in the U.S. in regards to maternity care standards and accessibility. For many, the maternity care system in the U.S. does not require revision, but for a growing community of birth advocates and pregnant women, change is not only wanted, but is needed.

CHAPTER II

THE CADILLAC OF MATERNITY CARE

Luxurious. Superior. High-class. When a people in U.S. hear the word "Cadillac," they usually think of automobiles, but not just any automobile. They think of ones representing the very best. For over 100 years, people in the United States have known that Cadillacs are top-of-the-line cars—cars that many aspire to own. Owning a Cadillac is a sign of privilege and class; they symbolize the best of the best. These associations have been ascribed to the word Cadillac for over a century, and it is safe to assume that when it is used in contexts outside of the automotive world, it is meant to represent luxury, superiority, and high-class.

Based on the statements given by the American College of Obstetricians and Gynecologists, the majority of people in the United States have been led to believe that our country has the "Cadillac" of maternity care (Wagner 2006:9). While not everyone believes this statement to be true, less than 1% of all births occur outside hospitals (Sakala and Corry 2008). Virtually all of the women in our country have delivered, or will deliver a baby at a hospital. Even low-risk pregnancies are handled at hospitals with physicians. There has been a "standardization and routinization" in the U.S. birthing system, which "has no institutionalized mechanism for separating normal from complicated births" causing the treatment of "all kinds of births with the same set of procedures" (Jordan 1993:61). Because hospital births are what most women experience, it is worth asking: does the United States really have the "Cadillac" of maternity care systems?

It could be said that the United States has the Cadillac of maternity care systems when the cost of having a baby is considered. Because most births occur within the walls of a hospital, childbirth is the leading reason for hospitalization in this country, and maternity care hospital charges amount to $79 billion (Lusero 2012:1). Attributing to the high cost is the very common

use of interventions during hospital births. Cesarean sections are on the rise in this country, with the CDC identifying that 32.9% of all births in a year are C-sections (Joyce et al. 2011:9). Depending on the complications encountered, C-sections can result in nearly tripling the cost of a vaginal birth (Sakala and Corry 2008:2). The drastic increase in the rate of cesarean sections "reflect changing professional standards, with growing casual acceptance of cesarean surgery, lowered thresholds for applying traditional indications, and the appearance of new and unsupported justifications such as 'baby seems large'" (Sakala and Corry 2008:43).

There are 10,697 registered and community hospitals in the United States (American Hospital Association 2013). The maternity wards have shifted from having three separate environments (labor room, delivery room, recovery room) to using single birthing suites where the woman can remain in a single location. Despite these changes, most hospitals still have an "unmitigated hospital atmosphere" that "is familiar as a place of illness and suffering, a place for patients" (Jordan 1993:69). In the U.S., the staff in maternity wards amount to 40,000 OB/GYNs. Each of these obstetricians/gynecologists have spent eight years in undergraduate and medical school, one year as an intern, and at least three years of specialty training in obstetrics and gynecology (Wagner 2006:17). The OB/GYNs practicing in the United States have undoubtedly been trained and prepared to attend births. Unfortunately, it is often forgotten that OB/GYNs are highly trained specialty surgeons, and surgeons have a different approach to labor and delivery than non-surgeons. Most physicians recognize that it is best to do nothing during normal births, but "their professional training and work orientation militate against that attitude" (Jordan 1993:61).

Because we tend to have surgeons attend all births instead of only the high-risk or problematic births, we have more interventions than necessary. Allowing surgeons to attend all

deliveries is not the only reason for the high rates of interventions; convenience and threat of litigation must also be considered. Because delivery can last for a very long period of time, doctors use interventions to speed up the process so that it better fits their schedules (Sakala and Corry 2008:35-43). Natural delivery averages 12 hours, occurs 24 hours a day, 7-days a week. Devoting this much attention to patients can be very difficult for some doctors and greatly encroaches on their personal lives. The Center for Disease Control and Prevention has examined birth certificates in the U.S. and has discovered that the percentage of births that happen "Monday-Friday, nine-five, is rapidly increasing" (Wagner 2006:39). With physicians able to suggest scheduling induction dates or even scheduling a cesarean section with no medical reason, more often they are able to influence, if not completely control, the time they must spend at the hospital. The average C-section lasts for approximately 20 minutes—a much more convenient amount of time than 12 hours.

Not only are C-sections more convenient for doctors, but they are believed to be the "safer" option by many physicians. Even though a C-section is major abdominal surgery, there is a smaller chance for litigation from a C-section than from a vaginal birth (Wagner 2006:40-42). Many physicians deter from humanizing and personalizing the birth experience because of the increasing cost for malpractice insurance and the ever-present threat of lawsuits (Davis-Floyd 2003:48). Studies have shown that the women in the U.S. most likely to receive a C-section are White, married, have private health insurance, and are educated. This combination is interpreted by many obstetricians as a woman who is more likely to sue if something goes wrong, and therefore "encourages doctors to perform 'defensive' C-sections" (Wagner 2006:42). These women are also more likely to choose to have a C-section because of their "attitudes about pain and vaginal tone" (Wagner 2006:42). Instead of advising women against such an invasive

method of delivery without clear medical indications, many obstetricians allow women to make this choice because it is more beneficial to them than to have a woman want a natural delivery.

Women fall victim to hospital interventions sometimes unknowingly. Many interventions lead to one another, causing a chain reaction that can have detrimental results. One common practice is the induction of labor through administering powerful drugs like Pitocin. This synthetic form of oxytocin is used to induce labor and/or speed up labor for approximately 40% of births in the U.S. (Childbirth Connection 2013, Wagner 2006:96). With the increase in uterine contractions, many women begin to experience increased labor pain. The increased labor pain leads many women to request an epidural block to ease the pain; epidurals can cause labor to slow down. When labor has slowed down, it is interpreted as a "failure to progress" and leads doctors to pull out the baby with forceps, a vacuum extractor, or by C-section (Wagner 2006:39). For many women, the induction of labor is needed for medical reasons, like a pregnancy that has lasted more than 41 weeks or high blood pressure toward the end of pregnancy (Childbirth Connection 2013). When a woman and her physician decide to induce labor without any medical reason, there is an increased risk for babies. Especially if induction is done before 39 completed weeks of pregnancy, babies may have breathing problems, infection, and admission to a neonatal intensive care unit (Childbirth Connection 2013). In addition, a large amount of brain growth and development occurs during the last weeks of pregnancy, and babies born before their due dates have more learning and behavioral problems than babies born after 39 weeks (Childbirth Connection 2013). Not only do risks increase for the baby, but the chance of having a C-section greatly increase when labor is induced before 41 weeks (Childbirth Connection 2013).

The use of so many interventions may be attributed to the medical system "convincing women of the defectiveness and dangers inherent in their specifically female functions" (Davis-

Floyd 2003:53). The common belief held by people in the United States is that a woman's body cannot handle delivering a baby without something going wrong. This has led many to approach birth with a "just in case" perspective, and therefore permits the use of interventions when they are not medically needed. Unfortunately, when one intervention is used, it justifies or increases the likelihood of using others (Declercq et al.2006).

Some examples of other hospital interventions include electronic fetal monitoring, rupturing membranes and episiotomy. Electronic fetal monitoring is nearly a universal practice even though there is not necessarily a health benefit or risk from using/not using electronic fetal monitoring (Sakala and Corry 2008:48). Unless the monitor is wireless, it inhibits mobility and forces the woman to stay in her hospital bed throughout labor. In the Listening to Mothers II survey, 76% of women reported continuous monitoring which inhibited mobility and was uncomfortable (Sakala and Corry 2008:48). Because there is no hard evidence that women should have continuous monitoring, it should be used less frequently. Another procedure that is prevalent is rupturing the membrane. Doctors use a small crochet-like hook to puncture the membrane containing the fetus, amniotic fluid and umbilical cord to induce labor. Once again, there is no hard evidence that the procedure shortens labor, increases maternal satisfaction, or improves newborn outcomes (Sakala and Corry 2008:49).

Another procedure with no proven benefit is the episiotomy—a cut made do enlarge the vaginal opening right before birth (Sakala and Corry 2008:49). This surgical cut has actually been proven to be worse for a woman than a natural tear; the irregular and ragged lines of a tear follow the lines of tissue which can be brought together "like a jigsaw puzzle" (Wagner 2006:56). Episiotomy cuts ignore "anatomical structures or borders and disrupts the integrity of muscles, blood vessels, nerves, and other tissues" which results in "more bleeding, more pain,

more loss of muscle tone, and more deformity of the vagina" (Wagner 2006:56). Despite the fact that for decades this procedure was believed to be necessary, it actually increased perineal injury, need for stitches, high increase in pain and tenderness, and a prolonged healing period (Sakala and Corry 2008:49). The rate of this intervention has decreased, but as of 2002, the national episiotomy rate was 35% (Wagner 2006:57). While the use of some of these procedures is declining, they are still prevalent during many deliveries, and they only increase the cost of a hospital birth.

Analgesia during labor and delivery is one of the perks of going to a hospital for delivery. According to the Listening to Mothers II survey, 86% of all women having a hospital birth used some form of pain medication (Sakala and Corry 2008:54). Over three-quarters of women who reported in the Listening to Mothers II survey indicated that they received an epidural (Sakala and Corry 2008:39). Many women, however, were unaware of some of the adverse effects associated with epidurals including: immobility, sedation, fever, hypotension, itching, longer pushing phase in labor, and perineal tears (Sakala and Corry 2008:39). Epidural analgesia also affects the newborn by causing an increased heart rate, hyperbilirubinemia (jaundice), and poor performance on newborn assessment scales (Sakala and Corry 2008:39). Despite these potentially harmful effects, many women still seek out pain medication during labor.

As stated earlier, for 99% of women in this country, going to a hospital to deliver a baby is safe, provides comfort, and is the "right" thing to do. Hospitals attempt to provide an "ordered structure to the chaotic flow of the birth process," but sometimes that ordered structure is not what is best for mothers and babies (Davis-Floyd 2003:152). The current system also uses many interventions, which creates a "distorted understanding of childbirth as a time when things are

likely to go wrong and intensive medical management is required" (Declercq et al.2006). Because birth in the U.S. is culturally accepted as a medical event, both practitioners and their clients are of the assumption that "American birth practices, are, in fact, scientifically grounded" (Jordan 1993:123). Even though our country accepts the technocratic model of birth, it is not the only approach women have in the U.S.

Options Outside of the Hospital

As science and technology progressed in the late 19th century, the concept of giving birth at home was old-fashioned, dangerous, and unnecessary. It was during the early 20th Century that aseptic and antiseptic methods became part of the medical approach, and the midwifery model of care became scrutinized (Jordan 1993:51). Because the development of state infrastructure and medical infrastructure went hand in hand, physicians had legal backing to change medical practices in the state (Lusero 2010: 3). Physicians attributed the high rates of infant and maternal mortality to "unsanitary and superstitious practices" (Morrison 2010:1). It was argued that prohibiting midwifery would yield noticeable improvements in maternal and infant care (Morrison 2010:1). Moving births from the home to the hospital was an ultimate sign of progress and science. It is true that infant and maternal mortality rates decreased initially during this shift from home to hospital, but it is not due to obstetric management but instead due to "the antibiotic revolution, the use of blood and blood substitutes, and things like improved nutrition and antiseptic procedures" (Lusero 2010:17). This transformation was driven not only by the advance of science, but "the demands and example of an industrializing capitalist society" (Starr 1982:146). Larger numbers of people moved into urban centers and became detached from "traditions of self-sufficiency", and ideals of "specialization and technical competence" were projected onto them (Starr 1982:146). By 1955, 99% of all births were occurring at hospitals, and

the attempted elimination of midwifery helped create a "monopoly that impacted the marketplace of ideas in much of the same way that a monopoly impacts the marketplace of goods: prices increase, quality decreases, and there are less producers" (Lusero 2010:6).

In a time span of 50 years, nearly all women were making the journey to a local hospital when it was time to deliver. This behavior has survived for an additional 60 years, and hospitals are still the main location for births to occur in the United States. Midwifery is making a comeback in the U.S., and despite the cultural norm of delivering at hospitals, a growing number of women in the country are leaving hospital births behind in favor of delivering at a freestanding birth center or at their own home (Jordan 1993:65).

Data collected in 2006 indicated that of the 4,265,555 births in the U.S., only 0.90% took place outside of hospitals (MacDorman et al. 2010:2). Because such a small percentage of women choose to have non-hospital births, they comprise a minority culture (Boucher et al. 2009:119). This minority culture of women choosing to stay home to give birth has been the focal point of many studies, and it is from those studies that we know the characteristics of those women (Boucher et al. 2009, Lindgren et al. 2008). Some of the characteristics of women who are more likely to have a homebirth include: non-Hispanic White women, married women, women over the age of 25 years, women with several previous children, and some select populations of women who have larger families (MacDorman 2010:5). Of the 0.90% of non-hospital births, almost two-thirds (64.7%) were homebirths, over one-quarter (28.0%) took place at a freestanding birth center, just over 1% occurred at a clinic or doctor's office, and 6.2% were somewhere else (i.e. in taxi on way to hospital) (MacDorman et al 2010:2). The majority of homebirths were planned with their attendants to ensure the best possible outcomes (Boucher et al. 2009:119). Midwives (including CNMs and direct entry midwives) attend the majority of

homebirths (MacDorman et al 2010:4). Women choosing homebirths are also "better prepared" for birth and there is a "great degree of satisfaction reported by homebirth families" (Jordan 1993:71). Some of these options may not be well-known, but there are options available to women who do not want to deliver their baby at a hospital.

Because out of hospital births are so uncommon, studies have been done to compare the outcomes of home and hospital births. Vastly different from the U.S., in other developed countries midwives attend 50-75% of births (Goodman 2007:611). International studies have long supported the idea that homebirths with a midwife are just as safe as hospital births when the pregnancy is low-risk (Johnson and Daviss 2005:6). These studies identified that good outcomes are achieved with little use of interventions, and a dramatic decrease in cost (Johnson and Daviss 2005:6). A study conducted in Sweden discovered that women giving birth in a hospital were five times more likely to have perineal trauma including sphincter or rectal ruptures and were 10 times more likely to have an episiotomy (Lindgren et al. 2008:756). Two industrialized countries that embraced the opinion that birth happens spontaneously and effectively are Holland and Sweden. The births in these countries are attended primarily by midwives, and in Holland, over fifty percent of births take place at home (Jordan 1993:48). A broad North American study discovered comparable results to those from international studies, suggesting that low-risk pregnancies are just as safe if not safer at home than at a hospital (Johnson and Daviss 2005:6). Other studies have compiled the results of home and hospital births to conclude that maternal and neonatal outcomes of planned homebirths are favorable when compared to planned hospital births (Boucher et al. 2009:119). These studies were not only able to examine the safety of homebirths, but they also identified some common themes about why women choose to have homebirths. Themes uncovered include a woman's desire for more

control during her delivery, having freedom to move around, safety, and lack of interventions (Boucher et al. 2009:121). Another benefit to using a midwife and being at home was the complete attention that was given to the woman during delivery; the midwife could devote all attention and energy to the mother instead of dividing her time and focus between patients (Lindgren et al. 2008:757). Data has shown that nurse-midwives actually gave better care during a pregnancy and spent an average of 23.7 minutes with their patient per visit as opposed to only 9.5 minutes that an obstetrician spent with a patient (Dempkowski 1982:11). There is ample evidence indicating that safety is not an issue when it comes to homebirths, yet they are still underutilized in the United States.

Unfortunately, the proven safety rates of homebirths have not led to any meaningful support from the U.S. government, professional organizations, insurance companies, or even society (Boucher et al. 2009:119). One of the major influential organizations in the United States is the American College of Obstetricians and Gynecologists. This organization opposes homebirths and believes that choosing to deliver at home "places the process of giving birth ahead of the goal of having a healthy baby" (Janssen et al. 2009:377). The lack of support for homebirths is even more questionable when the World Health Organization identifies that "70-80% of all births are normal and uncomplicated" (Goodman 2007:611). The fact that healthy babies are born outside of hospitals with the help of a midwife does not have any influence on their stance. Studies have proven that "midwives use fewer interventions and their clients experience significantly lower cesarean birth, low birth weight, and neonatal mortality rates" (Goodman 2007:611). Despite the efforts of hospitals to offer world-class care in maternity units, many are "not providing evidence-based maternity care, appropriate care for low-risk women, labor support techniques for pain relief, nor support for the natural ability of low-risk women to

give birth vaginally without technological interventions" (Boucher et al. 2009:124). Clearly, the procedure-intensive maternity care system that exists is only being questioned by a very small percentage of individuals and is widely accepted by the majority of people in this country.

When deciding if the United States actually has the "Cadillac" of maternity care systems, several factors must be considered. The dominant cultural definition of the birth event in the U.S. is that it is a medical event (Jordan 1993:123). We pay more than many other industrialized countries, which may lead one to think that we have the best system, but our outcomes are not as good as other countries who pay much less (Lusero 2012:1). For women with private insurance, choosing to deliver a hospital is appealing because of some of the changes that are occurring in the labor and delivery units. Maternity wards have now been replaced with "family-centered birthing suites" (Boucher et al. 2009:119). Some hospitals have created labor and delivery brochures that entice women; they have whirlpools, spa treatment, and the latest machines and amenities in each birthing suite (Boucher et al. 2009:119). Clearly, for-profit hospitals are attempting to make the delivery rooms more comfortable and home-like for laboring women. Women have access to many different drugs to induce labor, speed up labor, and manage pain; these drugs can be interpreted as a symbol of luxury. Unfortunately, many of these drugs can have terrible outcomes and are not always administered for medical reasons. For example, trained physicians attend births, which can be viewed as a huge advantage in our system. The only problem is that these physicians are trained surgeons, and view the laboring women as a patient with an ailment that needs to be fixed. The system we have is equipped to handle problematic births, and for those rare cases, the maternity care system in the United States is great the way it is. For the majority of women, however, the current system is presented as the best, when in reality, other options may be better for both mom and baby. If we truly want to

have the "Cadillac" of maternity care systems, we need to have multiple options available for women so they may choose what is best for them and their babies. The focus should be on mom and baby instead of obstetrician and hospital cost.

Options in Colorado

When looking at the history of the state, it is clear that the development of state infrastructure went hand-in-hand with the development of medical infrastructure (Lusero 2010:3). Colorado became a state in 1876, and five years prior to Colorado becoming a state, the Colorado Territorial Medical Society was formed (Lusero 2010:3). Shortly after this point in history was the creation of universities and medical schools, and as a result, there was a growth in medical training (Lusero 2010:4). The early 1900s was a developing period for obstetrics; in order for obstetrics to flourish, midwives had to be undermined and challenged.

It has only been within the last 30 years that midwifery has regained support and momentum in Colorado. Midwifery was inhibited in Colorado in 1941 with the passing of Senate Bill 640 which ended midwifery licenses and positioned medicine as the only legally recognizable form of care for childbirth (Lusero 2010:8). Early research done by Dempkowski in the 1980s was very important to the field because it showed that midwifery was more cost effective and provided quality care; it also sparked research to be done on the safety of using a midwife. The late 1990s brought about legal changes to the terminology used about midwifery in Colorado, and made the use of a midwife legal once again (Lusero 2010:14-15). It is evident that the rise of the state and the hospital greatly influenced maternity care in the state of Colorado, and that the effects of early legislation can still be seen today.

Hospitals are the most accessible option for expectant mothers in Colorado—there are 185 hospitals spread throughout the state (Colorado Hospital Association 2012). While most

women in the state choose to deliver their babies at hospitals, it is important to note that Colorado is one of the few states in the U.S. that has a higher percentage of homebirths than the national average (MacDorman et al. 2010:3). More than 1% of births in Colorado are homebirths, and a growing number of women are choosing to deliver at the single freestanding birth center in the state--Mountain Midwifery Center of Colorado. Even though there is only one birth center in Colorado, the state has options outside of the hospital available to women. The question now is, where and why are women choosing to go during labor and delivery?

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

The goal of this research is to understand how and why pregnant women make decisions about their birth. Many different fields study this topic, including obstetrics, midwifery, public health, but none of them focus on what the pregnant women are really saying. These studies quantify findings or discuss themes without individual stories. As an anthropological project, it was essential to listen to the stories and opinions of the women so that the issue can be humanized.

Not only were women asked about decisions they have made about their pregnancy, but they were also asked to express their thoughts and opinions about the current maternity care system. Because the implications of this research can lead to some interventions or recommendations for policy change, the methods used are primarily drawn from applied anthropology (Trotter 1998:691). This research fits broadly into three types of applied situations which are: policy research, cultural intervention research, and advocacy or action research (Trotter 1998:692-693). Of the three situations, this project aligns best with cultural intervention research because the data should help us "identify cultural factors important in guiding interventions" (Trotter 1998:693). It is recommended that partnerships are established in the field of applied anthropology because partnerships "are necessary for evaluating the implications of policy decisions or for developing and testing programmatic interventions" (Trotter 1998:695). Because I am a member of the birth advocacy group Elephant Circle, I have a team to collaborate with for future projects. The team is made up of people with different backgrounds including a social worker, lawyer, and doula. This membership helps guarantee elaboration on this research once this project has been conducted. Having a partnership with Elephant Circle allows for the

findings from this project to be used or built upon in the future. When thinking of potential future projects, it became very important to ask the women in this study what changes they would like to see in the maternity care system.

Research Aims

The aim of this study is to gather data that will aid future projects and policies, but it cannot be overlooked that the subject is extremely broad and controversial. As previously mentioned, government, society, and prestigious organizations are hesitant to advocate for homebirths and midwifery as an available option to all people. Because there are such polarized views on the subject, this study is not attempting to gather broad generalizing data. Studying a group of women in Colorado is not representative of all women in the area, the state, or the country and should not be taken as such. Instead, this study will use qualitative methods to gather data about women in Colorado. The rich qualitative stories will provide some insight, and can be used to create replications in other areas of the state, or to design follow-up projects.

This research project obtained IRB approval in early January 2013, and recruitment for participants followed shortly after approval. Based on the guidelines provided in *Qualitative Methods in Health Research*, the target population should relate directly to the specific aims of the research (Thorogood and Greed 2009:6). Keeping the specific aims in mind, this project targeted women who currently are pregnant. The decision to only talk with current pregnant women comes from the desire to avoid discussions about speculations (what a woman wants once she is pregnant) and to avoid discussions about hindsight (this is what I wish I had done, etc.). While both of these discussions would be valuable and provide some interesting conversations, they will muddle the current study about decision making process as they are happening. Knowing how/why decisions are made while the mother is pregnant is the whole

focus of this study, and including women who have never been pregnant, or who can look back does not seem beneficial at this time and point

Targeting pregnant women is still a very broad population, a population full of variation and differing habitus'. The allocated time for this research was about six months, which expedited recruitment of participants. Because of time constraints, snowball sampling was used to recruit pregnant women for the study. Flyers for recruitment were given to The Pregnancy Wellness Center of Parker and to members of Elephant Circle (Appendix B). The flyers were passed along to pregnant women, midwives, and other individuals working in the realm of birth. Participants contacted me if they were interested in the study, and after our interview was complete, I asked for contact information for any other pregnant women they knew who would be interested in participating. This sampling choice may be seen as a form of sampling bias because it could potentially be excluding certain types of women. This decision, however, was made with the original goal in mind: to better understand the decision making process of pregnant women when it comes to choosing a birth attendant and method of delivery. There is no feasible way that this study could target women of all different socioeconomic statuses in the timeline allotted, but variation was desired.

The design of the interview guide allowed characteristics such as age, ethnicity, education level, and socio-economic status, to be pulled out during the interview process. Saturation sampling is one of the ideal methods to use because it is preferred when exploring cultural domains or cultural consensus studies (Trotter 1998:703). Birth is the cultural domain being explored in this study, and there is general consensus about the subject which is why consensus modeling will be used to define and analyze structural relationships (Trotter 1998:710). This technique is appropriate because it will allow for discussions pertaining to the

consensus about maternity care in the U.S. and the participant's personal feelings and opinion on the subject (Trotter 1998:710). In order to obtain in depth answers about the decision making process, semi-structured interviews were conducted with nine participants. Notes were taken during the interviews and the conversations were recorded and transcribed. The coding of the interviews allowed for further analysis to be done and themes to be identified. The questions that guided the interview were aimed at getting the participant talking about her ideal birth experience, her mother's birth experience, who she's talked with about delivery, and about the cost of delivery. A copy of the questions can be found in Appendix A. Interviews were conducted in a one-on-one fashion in public, non-threatening or intimidating spaces like parks, coffee shops, and restaurants.

The data collected were analyzed within the theoretical frameworks discussed below. It has been of extreme importance to consider "cognition and behavior since the relationship between them is not always predictable" (Trotter 1998:708). Results were also compared to the national and international studies used as references to determine the consistency of some of the themes revealed in the ethnographic data.

Conceptual Framework

This study is grounded in practice theory as articulated by Bourdieu and Giddens. Bourdieu's habitus and practice is used as they relate to larger issues of structure and agency. According to Bourdieu, objective structures create the social conditions that produce habitus (Bourdieu 2001:533). Every "agent" is a "producer and reproducer of objective meaning" which leads to an "orchestration of habitus" (Bourdieu 2001:534). In a general sense, Bourdieu believes that the orchestration of habitus creates a world in which individuals have very similar if not identical experiences. Because the habitus is a product of history and "produces individual and

collective practices" it is very important for this study to consider the habitus, structures, and practices that are related to the birth process in the United States (Bourdieu 2001:534).

Similar to Bourdieu's structure, habitus, and practice is Giddens' theory of structuration. Action and structure are seen as being part of a recursive loop consisting of "actions influenced by social structures and social structures (re)created by actions" (Ahearn 2001:117). This model can be applied to the way birth is viewed and treated in the United States; women have babies in hospitals because that is what they are told is the right thing by others, is what their mother did, or is the only option they are aware of, which perpetuates the belief that births need to occur within the hospital with an obstetrician.

This research also draws on the theory of agency. For this project, I will use the definition proposed by Laura Ahearn. Ahearn's agency refers to "the socioculturally mediated capacity to act" (Ahearn 2001:112). This research views women as agents because they are the ones "engaged in the exercise of power in the sense of the ability to bring about effects and to (re)constitute the world" (Ahearn 2001:113). The type of agency that is expected to be present in this study is oppositional agency; women who decide to use a midwife are choosing to take back control in their births because they are realizing that the "norm" has been forced on them. Including the idea of agency to analyze some of the decisions made will help us further understand the decision making process. This model is complementary with Giddens model of structuration because he incorporates agency—saying that individual actors change the structure as they behave and act within it.

Combining habitus, structure, and agency will aid the discussion about the decision making process. Studies coming from fields like philosophy and psychology examine decisions, judgment, and choice as they relate to behavior. Behavioral decision making theory was

considered and applied during analysis of the data to specifically identify the major influencing factors at play for this topic. Generally speaking, it is assumed that human behavior is purposive and goal-directed, and that some methods of reaching a goal are better than others (Einhorn and Hogarth 1981:1-2). When these assumptions are applied to birth, the picture becomes less clear; there are many decisions and outcomes that do not align with the theory of having purposive and goal-directed behavior. If the goal is to have a healthy baby with little adverse effects to one's own body, then why are hospitals and their procedure-heavy methods more accepted than homebirths? If there is evidence proving that homebirths are safe, then why aren't more individuals and households choosing homebirths? The responses from this study help address these questions.

Even though there appears to be contradictions between behavior and decision-making theory, it should be stated that the nature of the current maternity care system is conservative. Having a conservative system has influenced how birth is perceived which in turn affects the decisions that are made. The birthing location specifically "shapes resource availability and assignment of responsibility and credit for birth" (Jordan 1993:75). For many, it is more acceptable to deliver at a hospital where there are more resources available and the responsibility and credit can be given to a physician. Some may consider having a baby at home risky because if something goes wrong, the conservative nature of our system will cause people to blame the mother for not having the baby at the proper location.

According to behavioral decision making theory, family influence has been identified as a leverage point when making decisions about health (Grzywacz and Fuqua 2000:105). Family influence also plays a role in each participant's habitus, because how they were raised affects how they make sense of the world. It is not expected that women make these decisions alone,

and it appears likely that the experiences and opinions of family members influence the decisions made by pregnant women.

CHAPTER IV

WHAT WE'RE CHOOSING: THOUGHTS AND OPINIONS OF NINE PREGNANT WOMEN IN COLORADO

Over the course of two months, various women were interviewed about their pregnancy and decisions they have made. Fifteen women contacted me about the study, but only nine were able to meet up for interviews. All of the women were very open to discussing their experiences, thoughts, and opinions. Snowball sampling led me to many different cities in Colorado (Figure 1). Of the nine women interviewed, four are delivering at a hospital, four are delivering at home, and one is delivering at Mountain Midwifery Center. Descriptive characteristics of the women can be found in Table 1.

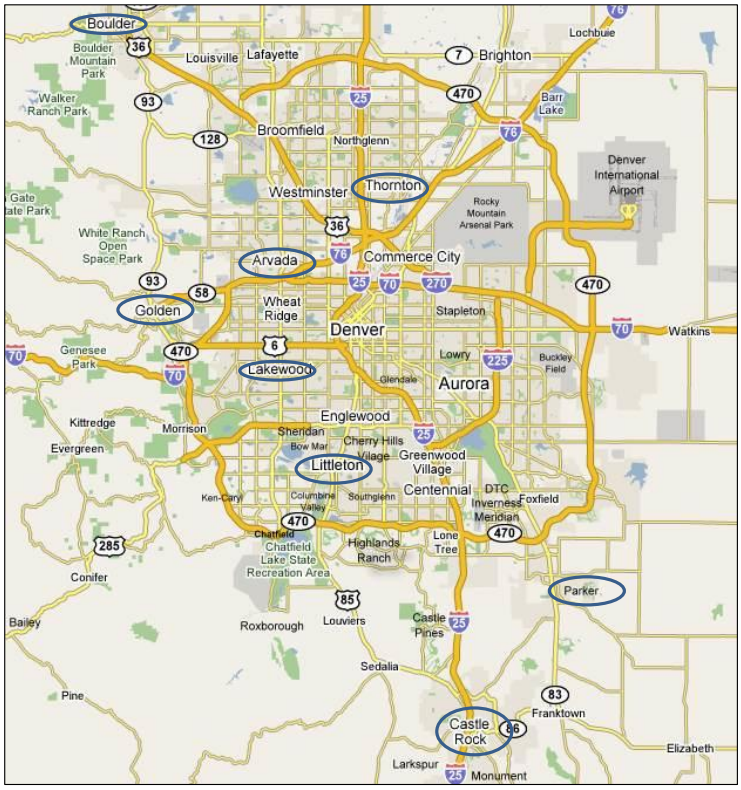

Figure I: Residency locations of women interviewed

The main purpose of this chapter is to present the results from the interviews. Being that this study was exploratory in nature, the responses of the women are essential in understanding what was influential when making decisions about their pregnancy. The common themes that came out of the interviews will be discussed below and analyzed in the next chapter. I will discuss the common themes among women choosing a hospital birth, and then I will discuss the themes among women choosing homebirths/Mountain Midwifery. Next, first-time mothers will be compared to the experienced mothers to highlight the important role experience plays in decision making. The chapter will end with a discussion about the problems these women see with the maternity care system and the solutions they have to these problems.

Table I: Characteristics of Participants

Delivery Location	Number Pregnancy	Travel time to Doc/Midwife	Age	Weeks Pregnant	Marital Status	2013 Due Date
Hos	First	<10 minutes	30	20	M	21-Jun
Hos	First	10-15 minutes	26	27	IR	11-May
Hos	First	< 10 minutes	27	20	M	19-Jul
Hos	Third	35 minutes	30	27	M	20-Apr
Hom	Third	16 minutes	35	33	M	10-Apr
Hom	Tenth	< 1 hour	39	11	M	1-Sep
Hom	Third	10-15 minutes	27	31	M	14-Apr
Hom	Fourth	25 minutes	37	33	M	15-Apr
BC	First	35-45 minutes	35	25	IR	21-Jun

Key: M=married, IR= in relationship, Hos=hospital, Hom=home, BC=birth center

Hospital Births

Four of the women in this study have decided to give birth at a hospital, and these women shared similar characteristics. Three of the four women are first-time moms, and one was on her third pregnancy. All of the first-time mothers expressed feelings of fear during our conversation. Sometimes they were simply referencing how scary the unknown is, and other times it was specifically about all of the problems that could go wrong during delivery. One woman, Stacie, said that she watches the television show "A Baby Story," and that she will not be making a birth plan because the show has proven to her that anything can go wrong, and that there is "no point

in trying to control what happens during birth." Another woman, Kelly, said that she will not watch shows like "A Baby Story" because they "scare the crap" out of her. Influences from the media are not the only factors that make Stacie fear birth. She talked about how her mother always said that giving birth was the worst pain she ever experienced; hearing her mother speak of birth this way has also led Stacie to dread giving birth. She told me, "I don't want to deal with pain…it's scary." Despite the fact that Stacie has never experienced giving birth before, she has allowed the opinions and portrayals of birth from the media shape her view on the topic. While we were talking, Stacie said that she is definitely planning on having an epidural so that she will not have to experience the pain of delivery, and that she will be putting all of her faith into the hospital and hands of the doctors.

Julie and Kelly were not as explicit about fear, but the theme did present itself in our interviews. Julie is delivering her baby at a hospital that has both obstetricians and certified nurse midwives available. During her initial visits, she was meeting with midwives, but after she experienced some spotting, she decided that she would be more comfortable working with an obstetrician "just in case" she has "serious problems." As the topic of midwifery entered our conversation, Julie said that she could only have a homebirth if there was "a 100% guarantee that nothing would go wrong." Because she cannot have this guarantee, she and her husband feel more safe having the baby at a hospital. Kelly seemed more nervous than fearful about giving birth. She does not trust her body to handle pain well, and she mentioned several times that she wants to be at a hospital "just in case something goes wrong." For the women giving birth at a hospital, they appear to find a lot of comfort in the fact that they will already be at the hospital if/when something goes wrong. Despite being hopeful that their deliveries will be

uncomplicated, most of the women seem to think that something will go wrong because that is what they have heard stories about, and it is what is portrayed by the media.

Another theme that emerged during conversations with most of the women having hospital births was one of self-doubt. Julie, for instance, "highly doubts" that she will be able to deliver the baby without the use of pain medicine. She was not very firm about having a birth plan, and trusts that the doctors will guide her through what she needs including labor induction drugs, like Pitocin, and potentially a cesarean delivery. Self-doubt is also seen throughout the conversations with Stacie and Kelly; neither woman wants anything to go wrong, but they are of the belief that it is likely that something will go wrong, and therefore they need to be at the hospital under the supervision of an obstetrician. While all three of these women indicated that they would preferably like to deliver their babies vaginally with the use of pain medication, they also said that they are open to interventions if their physician recommends them. They do not have firm birth plans created, and do not think that they could ever have homebirths. When asked to elaborate on their opinions of homebirths, the most common responses were, "it's just not for me" and "I don't know…it's weird." It became clear that to them, the idea of having a baby outside of the hospital was too different from what is "normal" and increased the possibility of something going wrong. Interestingly enough, almost all of the women choosing a hospital birth did not personally know someone who had used a midwife or who had a homebirth. Not having a personal connection may be one of the reasons they view homebirths and midwifery with such skepticism.

These women differ greatly from Laura, the only woman delivering at a hospital who is not a first-time mother. Laura's experience aligns her more with the women having a homebirth because she is very vocal about what she wants and expects from her doctor. Her two previous

children were delivered at a military hospital where she did not have much of a choice in anything. Not only did she have no say in choosing her doctor, but she said that she had to do what they said. She recalls not being allowed to get up once labor had started, and how uncomfortable it was to be stuck in bed and immobile during labor. Because of her past experiences, it was very important to her to find a hospital and physician that allowed her to have more control. The hospital and obstetrician she has chosen will allow Laura to move around, change positions, eat whenever she wants, and sit in the tub. She has developed a very thorough birth plan and intends on sticking to it. Excuses like, "your baby is too big to have a vaginal delivery" will not work on Laura because she said, "my other daughters had huge heads (from their father's side of the family) and I know that I can handle delivering big babies." She does not want to be offered any form of pain medication, does not want to be given Pitocin to induce labor or to speed up the progression of labor, she does not want forceps or the vacuum extractor used, and she does not want a C-section unless absolutely necessary. The C-section rate for the hospital Laura is delivering at is just under 30%, which is "pretty good" according to Laura. Laura continuously mentioned trusting her body and knowing that her body is capable of delivering a baby; this theme was present in all four of the interviews with women having homebirths.

After listening to all of Laura's thoughts and opinions about birth and the maternity care system, it was surprising that she was not delivering at Mountain Midwifery or at home. When I brought this to her attention, she said that she had considered going to the birth center, but that it filled up too quickly and she couldn't get in. She also said that she would consider a homebirth, but that her husband would not allow that to happen because he hates blood and thinks the whole birth process is actually "pretty gross." These two issues represent barriers keeping Laura from

utilizing alternative options outside of the hospital. Laura probably would have chosen the birth center if a spot was available. With only one freestanding birth center in Colorado, accessibility becomes a major issue. The issue of Laura's husband not wanting a homebirth because it is "gross" highlights another major problem. If partners possess insufficient information on the benefits of alternative methods of delivery, then their opinions on the subject trump the woman's potential choice to deliver at home. Exposing all women to other options outside of the hospital is not enough; men must also be educated on the benefits of alternative delivery methods.

When comparing the women having hospital births, the factor dividing them pertains to experience. The first-time moms are the ones who are scared, doubt their ability to deliver, and trust hospitals. Laura, the only woman with previous experience giving birth, has completely different opinions on the subject. While none of these women said that they were unsatisfied with the care they are receiving, all of them did mention the brevity of their meetings with their obstetrician and how they wished that they had more time with the doctor. Stacie said that her doctor is open to answering questions she may have, but that she feels so much pressure when asked, "do you have any questions" that she can never remember what she wanted to ask. This has led to consulting books whenever she has questions. Julie also said that while she states that her doctors are open to answering questions, she sometimes feels like her inquiries are "shrugged off" or "not taken seriously." Kelly says that she does not feel rushed, but was very surprised at how short her appointments were. She told me that after her first appointment she was caught off guard because having a baby "is a big deal" but that her drive to the appointment was longer than the time spent with the doctor. Apart from wishing that the doctors spent more time with them, there was no other major critiques on what they wish was different or things they are unhappy with. The interviews with these women support the findings in the Listening to Mothers II (2006)

survey; they find the care they are receiving completely satisfactory and cannot identify changes they would like to see made.

Homebirths

All of the women who were having homebirths had already given birth at least once before. Two of the women had previously delivered at a hospital and decided to leave the hospital behind. One woman delivered her first child at Mountain Midwifery, and one woman had only delivered at home. The woman choosing to deliver at Mountain Midwifery has been included in this section because her thoughts and opinions align with the women having homebirths. An interesting find was the fact that all of these women were very similar in how they decided to have homebirths and what their feelings were about the birth process and the maternity care system in Colorado.

The two women who experienced hospital deliveries expressed feeling unsatisfied with the care they received. They generally felt rushed and like "just another patient" as opposed to a person. One woman, Lisa, said that after the birth of her second child, she was simply "fed up" with the medical world and thought that "there had to be a better way." She did not like how uncomfortable and unsupported she felt while delivering at a hospital. Her search for that better way led her to befriend women who used midwives and birthed at home. She believes that "God put these people in my life for a reason." Once she was exposed to the midwifery model and approach to birth, she said that she cannot imagine going back to the hospital to deliver. Sara was not as harsh when looking back on her hospital births. She had an unnecessary C-section because the ultrasound showed the baby to be breach. The physician decided to deliver the baby by C-section, but the baby was no longer breach when they cut open Sara. She wishes they had done an ultrasound before surgery to make sure it was actually needed. Luckily, Sara was permitted to

have a vaginal birth for her second child. She did not use any drugs and remembers that birth as "orgasmic." It was having such a wonderful natural delivery that Sara became extremely interested in birth and decided to become a midwife. While neither of these women believe that they had traumatic hospital experiences, they decided to leave the hospital behind and pursue a more natural and comfortable method of delivery.

Having control over their births was one of the main reasons all of these women decided to try having a homebirth. They see hospitals as trying to control a natural event—an event they do not think is meant to be controlled. Because of this, these women want the control to allow their bodies do handle giving birth without the interventions of the hospital. All of the interviews had to change course when the question of a birth plan was brought up. Women having their baby at home do not need to create a birth plan because they are in control of the situation. They all said that they do have to meet with their midwife to create a "plan b" in case they have to transport to a hospital. Fear was not an issue for these women. None of the women in this group ever mentioned feeling scared or fearful about giving birth. They trust their bodies to handle birth and they trust their midwives. Lisa told me, "my midwife is trained to know normal, and if I don't fit within the parameters of normal, she knows that I should be moved to a hospital." This approach is nearly the opposite of the approach taken by many obstetricians who are trained for the abnormal, but try to handle the cases of normal.

Trust was another main theme that emerged out of the interviews with women having homebirths. They do not believe that problems are more common than not, and they do not believe that Western drugs are the only solution for pain. Erin told me that water therapy helped her manage her pain with her first child and that the tub is actually "the midwife's epidural." Being at home added to the comfort these women felt while delivering. They commented on how

safe they felt and how it was important to bring the baby into a loving environment when it was born. Lisa absolutely trusts her body during birth because she has experienced an unattended homebirth. During her third pregnancy, she planned to have a homebirth attended by a midwife, but when she went into labor, the baby came before the midwife made it to the house. She recalls that the baby came after only about ten contractions. When I asked her if she was scared during that experience, she said, "Not at all. My body knew what to do." All of these themes are reflective of the themes identified in the study conducted by Debora Boucher et al (2009) which identified safety, lack of interventions, and control as reasons why women have homebirths.

When I asked women how they became exposed to midwifery, three of the five said it was because of a friend or family member who educated them on the topic. Melanie has had all of her children at home, and it because a family friend trained to be a midwife. She said that she was grew up thinking that she would give birth at a hospital, but her views changed when this family friend exposed her to an alternative way of thinking about birth. It took very little time before Melanie was convinced that a natural approach was better than a medical approach. Another woman, Erin, had a friend deliver at Mountain Midwifery and she thought that the birth center sounded great. After her first meeting at Mountain Midwifery, she and her husband decided that it was where they wanted to deliver because it was welcoming and humanized birth. After her daughter was born, she decided that she loved being involved with birth and decided to pursue a career in the field. She is now a doula, and has encircled herself with friends with a similar mindset about birth. Lisa too, became exposed to the midwifery model through a friend, and once that exposure occurred, there was no turning back.

The other two women, Amber and Sara, were raised in countries where midwifery is widely accepted. Amber grew up in South Africa and England, and Sara lived most of her life in

New Zealand. They both attribute their views on birth to their upbringing in these countries. Sara said that in New Zealand, under universal healthcare, all women have the choice to have an obstetrician or a midwife as a birth attendant. According to Sara, over 85% of women in New Zealand chose a midwife instead of an obstetrician because birth is viewed as something normal and natural. She is an advocate of humanizing birth, and she told me one of her favorite sayings, "pizzas are delivered, babies are born." When I asked Amber about how birth is treated in England, she said that most births occur at hospitals; but that they are attended to by midwives and that interventions are not used as frequently as they are in the United States. She recalls growing up with the knowledge that her body can handle the pain of giving birth.

Amber wanted to have a homebirth, but her partner was not receptive to the idea. They decided to compromise, which is how they decided to have the baby at Mountain Midwifery. She has been thoroughly satisfied with the care she has received, and is very comfortable with her choice. She too expressed the belief that her body was made to give birth and that she does not think that she would be comfortable or supported at a hospital. Despite not wanting to give birth at a hospital, Amber was very appreciative when she spoke of hospitals and doctors. She is grateful to have the facilities and care of physicians when needed, but is not of the belief that physicians are needed at all births.

Each of the five women also indicated that they have spread the knowledge about midwifery and homebirths within their circle of friends, and that many people in their lives have left hospitals behind. For many of them, they chose to have a more natural approach to birth once someone else in their life exposed them to this way of thinking. This suggests that change will be brought about as more women choose a method outside of the hospital and share their experiences with the other people in their lives.

The Role of Experience

A commonality to note is that all of the women opting to have a homebirth are experienced mothers. They have already given birth at least once, and know what their bodies are capable of. Experience is the most influential factor in these women choosing to try something different. They do not have to be as fearful as the first-time mothers because they have their own experiences to draw upon as opposed to relying on what the media portrays and stories of family and friends. All of these women also are very well educated about the maternity care system and the birth process in general. One woman is a trained midwife, another is a doula, and the other two have taken it upon themselves to research birth in the United States and abroad. Even though Laura has decided to have her third child at a hospital, she is very passionate about birth and the maternity care system. Amber is the only first-time mom giving birth outside of a hospital. Even though she has not given birth before, her cultural upbringing taught her to trust her body and what it is capable of. All of these women are confident in their bodies' ability to deliver child naturally, and they all believe that natural birth is worth advocating for. For the women who have given birth before, they had very positive experiences. Not a single negative story was shared during our interviews which may be one of the reasons they are so passionate about spreading the knowledge that birth can be safe outside of hospitals.

The women choosing to deliver at a hospital are satisfied with the care they are receiving, but all of the women using the midwifery model of care indicated that they perceived hospital care as impersonal and rushed. Erin had the misfortune of having a miscarriage when she was on her second pregnancy. When she realized what was happening, she didn't know what to do. Because she had her first child at Mountain Midwifery, she decided to call them. When the nurse answered the phone, Erin could hear the hustle and bustle of the office; the nurse was shuffling

papers, typing, and answering phones. When Erin said, “I think I’m having a miscarriage” the nurse stopped everything, was genuinely sympathetic, and talked with Erin. The nurse told her that she should have an ultrasound to confirm the miscarriage, so Erin went to a hospital nearby that accepted her insurance. When making the appointment, the nurse was impersonal, distant, and asked questions about the baby’s due date, which was difficult for Erin to talk about since she lost the baby. She recalls that the doctor was nice enough, but used words like “the fetus” when talking about her baby, and said, “at least you’re still young.” This last comment was hurtful and angered Erin. The experience at the hospital strengthened her position to never actively choose to deliver at a hospital.

When asked how long their appointments were with their obstetrician or midwife, the responses ranged from 5-15 minutes for obstetricians, and for midwives, the responses were never less than 30 minutes. Most of the women using a midwife said that they spend about one hour with their midwives. Spending this much time increases the level of comfort these women feel with their midwife, and they feel important. Melanie has had all of her children at home, and she loves that her midwife knows her kids. Her children come to all of her appointments with the midwife, and Melanie appreciates the loving atmosphere that exists with her children and her midwife. The midwives also appear to spend more time explaining things and answering questions. Even when Julie met with midwives at the hospital, she indicated that they spent more time answering her questions and did not make her feel as rushed as the doctors made her feel.

The first-time mothers delivering at a hospital did not appear to know about some of the statistics about interventions and cost, because they did not have any problems with the maternity care system. The only item they wanted changed was the length of the appointments with their obstetrician. Overall, they felt like their hospitals were accommodating to their needs,

safe, and they liked that pain medicine would be available to them. All of the other women, however, had much to say.

The main issue identified was the rate of C-sections. Not only do they "hate" how many women are given C-sections, but they hate how it can be due to convenience. These women would like to C-sections only being used when absolutely necessary, and do not believe that women should be able to have an elective C-section. Having too many options was also identified as a problem by these women. For example, Erin said that when a woman's obstetrician is suggesting something that he might see as just an option, the laboring woman sees it as "expert advice" that should be followed. Laboring women also are more likely to accept interventions when they are offered, especially when it comes to pain management and a shortened labor. Erin told me that she believes that there are "some evil doctors out there" and that more women should be aware of how the system works. Melanie also thought that more women should be exposed to the "truth" about the maternity care system in hospitals, and said that she would love to see doulas offered to all women choosing to deliver at hospitals, but that the doulas would have to be unaffiliated with the hospital. The comments made by these women mimic what is being said by birth advocates: lower interventions, increase care, decrease cost, and shift the way we think about birth. It should not be seen as a disease or ailment, but instead as something natural.

When asked how they think change should be brought about, they said that it could be very hard to change the minds of people, and that it will be a very slow process. The movement will have to be grassroots in origin, with a focus on awareness and education. Erin said that men should specifically be targeted because they are harder to convince than women about the safety of alternative methods. We talked a lot about the role fear plays in this country, and how we tend

to focus on fearful stories more than positive stories. Erin recalls stopping people who were about to tell her birth stories to ask, “Is this something I will want to hear? Will it make me feel good, or will this scare me?” Almost all of the women also said that they would love to see the positive stories of women who have used the birth center or had a homebirth spread to more people. The positive stories need to outweigh and be more prevalent than the negative stories. While none of the women had a very clear idea of how to bring about change, they did identify areas that they think should be focused on.

CHAPTER V

DISCUSSION

Erin's mother had pretty traumatic birth experiences, which affected both her mother and father's reactions to her having a homebirth. Erin was born four weeks early and after 30 hours of labor, she was pulled out with forceps. Erin's sister was also born four weeks early. After determining that the baby was breech, Erin's mother was taken away for an emergency C-section. Stuck filling out paperwork, Erin's father was not even told what was happening. Both daughters were healthy, and mom recovered, but these experiences have shaped how Erin's parents view birth.

When Erin decided to have her first daughter at Mountain Midwifery, she was met with some skepticism from both friends and family. However, her friends, who are younger, became excited, were full of questions, and supportive. Her family was hesitant to accept this choice, but was comforted by the fact that a hospital is across the street from the birth center. When she revealed that she and her husband have decided to have a homebirth with their second baby, their friends were intrigued and excited. Her parents and grandparents were quiet. Erin's father was the first person to speak, and the only thing he said was, "How long is the drive to the hospital?"

This story captures many of the experiences that are common when thinking about birth and maternity care in the U.S. Because of the experiences Erin's mother had, there was resistance to accept alternative methods from her parents and grandparents. Friends were open to hearing about what appealed to Erin about the birth center and homebirths, and she was able to spread the knowledge that influenced her choices. The lack of support from her family did not prevent Erin from pursuing the type of birth she wanted.

The nine women interviewed for this study provided some excellent insight about how pregnant women make choices about their pregnancy. When data collection first began in January 2013, I had some predictions based on the literature. For instance, I expected the women using midwives to be over the age of 25, White, and middle-class based on research collected by MacDorman et al (2010). The research done by Boucher et al (2009) identified some themes expressed by women having homebirths. These themes led me to expect that the five women in my study using a midwife and/or having a homebirth would tell me they wanted control over their birth, no interventions, and that the home provided a more loving environment than a hospital. When it came to influential factors, I expected to hear women tell me more about their mother's birth experience or the experiences of other important women in their life. This prediction is based on the idea that family serves as a leverage point when making choices about health because family influences "health-related attitudes, beliefs, and behaviors" (Grzywacz and Fuqua 2000:105). Some of these predictions were met, some were not, and I'm left with a rich repository of stories and views of birth.

As expected, all of the women using a midwife and/or having a homebirth were White middle-class women. While they did express themes of control, they tended to focus more on trusting their bodies with delivering a child. Melanie, who has had homebirths for all three of her children, said, "Why should I fear something my body was meant to do?" A surprise came when discussing the influence their mothers, grandmothers, sisters, aunts, and female friends. When decision making theory is consulted, one of the influential factors identified is the opinions of close family. Brief comments were made about their mothers' experiences, and when I asked if they consulted anyone in their family or circle of friends about their decision, every participant said no. The women delivering at a hospital did not consult anyone because it was the only

option they knew, and if their mothers had experienced painful deliveries or C-sections, it only added assurance that the hospital was the best place to be. As for the four women having homebirths, they made the choice with their partner and then informed family members and friends of their choice. They did say that some people were not very supportive at first, but that they did not allow the opinions of others to change their mind. Even though none of the participants actively sought advice from their family members, some of their choices stem from their habitus, including familial ties and upbringing. The women who grew up overseas (Sara and Amber) attribute their beliefs about birth to their cultural upbringing, which includes how their family talked about and approached birth. While explicit advice was not asked for, some of the women likely made decisions that reflect how they were brought up thinking about birth.

An interesting find that came out of this study was the fact that each group feels like their choice is the "safer" option. The women choosing to deliver are more fearful of birth and therefore find comfort in being at a hospital during delivery. It was difficult for them to even imagine what it would be like to stay home to deliver. Women choosing to deliver at home trust their bodies during birth and therefore feel safer at home where they will have control over their choices. Melanie indicated that she does not believe hospitals are good places to deliver because, "you have to fight for yourself and all of your choices." The women having homebirths are of the belief that hospitals are only the proper delivery location for a small percentage of deliveries, the deliveries that actually need medical interventions. These different explanations for their choices shows that the criteria for safety differs for people and it influences the choices made.

The way safety is thought about impacts control during birth. Women who believe that hospitals are the safest place to deliver are more likely to allow the physician and other medical staff to have much of the control during the birth process. These individuals have authoritative

knowledge ascribed to their position, which enables them to obtain control over deliveries with ease. Women who do not view hospitals as the safest delivery location will instead opt to maintain control over their bodies and their birth experience by delivering with a midwife at a birth center or at home. When thinking of birth, it is very clear that some want hospitals and physicians in control during labor, and other people do not want hospitals or physicians involvement whatsoever. Deciding who will have control heavily relies on the way the laboring woman perceives the safety of her options.

Having a healthy baby was the common goal of all nine women who participated in this research. The way the baby was delivered and the expected experience of giving birth was quite different. Two very distinct approaches to birth can be identified in the responses given in this project. One approach, which likely is representative of most of the people in the U.S., is to view birth as something to fear and something that needs the supervision of experts. The other approach is that birth is normal and that it can be assisted in ways that use little to no interventions. Both of these approaches are influenced by and shaped by knowledge and experience.

The women in this study who fit with the first approach are all first-time mothers, do not have personal connections with someone who has had a homebirth, and expressing feelings of fear and/or self-doubt. Based on the interviews, these feelings can be attributed to their habitus. All of their mothers delivered in hospitals, they have heard stories of terror from family and friends, and they primarily only see hospital births in the media. Having birth at a hospital is the option that feels right because of all the potential "what if" scenarios. When I asked questions about safety rates, C-section rates, and hospital policy about movement, eating, and alternative pain management techniques, Laura was the only person who answered. Even though Laura had

answers, she thought that her hospital's C-section rate of 30% was "pretty good". There is clearly a problem with the rates of C-sections if women perceive 30% as a good rate for a hospital. Some hospitals have C-section rates higher than 40%, so in this light, 30% is "pretty good" but it is not even close to being a good rate of 15% or less (World Health Organization 2012). The other women did not know and most of them had never even thought to ask or look into the statistics for their hospital. This lack of knowledge demonstrates how women feel comfortable with their choice of delivery location. When Julie said she would only have a homebirth if she had a 100% guarantee that nothing would go wrong, she did not seem to recognize the fact that hospitals cannot guarantee that every delivery will be problem free.

These themes about and approaches to birth is likely representative of most of the women in this country because 99% of all births are at hospitals. In general, Americans view birth as a medical event; this view "defines the parameters for birth location, admissible personnel, and support systems" (Jordan 1993:132). A medicalized approach to birth is what our country accepts, and it is what has led individuals to see as normal. The hospital structures, policies, insurance coverage, and the media create a world where babies are meant to be delivered at a hospital. Because of these factors, women in this country are raised with the understanding that they will have their babies at hospitals. The women in this study who are having homebirths said that they shifted their thinking about birth once they personally knew someone who had used a midwife or had a homebirth. Less that 1% of births nationally are homebirths, so the likelihood of knowing someone who has had one is unlikely. Approximately 4.3 million births a year in this county, and less that 43,000 will take place outside of hospitals. While the number of women using birth centers and homebirths is increasing, it is occurring slowly. With the spread of education about alternative methods and the sharing of stories, the rate may begin to go up at a

more rapid pace. Until more women use alternative methods of delivery, the current system and beliefs will be perpetuated.

As mentioned previously, almost all of the women who align with the second more natural approach to birth have delivered a baby at least once before. These women have been exposed to an alternative approach to birth by friends or family members—people they trust. Trust is one of the biggest factors influencing the women of this approach; they trust their bodies, they trust their midwives, and they trust the people who first brought this approach to their attention. The women choosing homebirths said that they cannot imagine going back to a medicalized approach to birth because they have the knowledge of other options and the knowledge that other options are safe.

Before I embarked on researching maternity care, I would have aligned myself with the first group. My mother nearly died when hemorrhaged after delivering my little sister. If she hadn't been at a hospital, I may have been raised without a mother. This story has been told many times throughout my life, but it is only now that I'm realizing how rare my mother's situation was. The horrific story about my mom's delivery reminds me that things can go wrong, and I relate with the women who are fearful. I remind myself to recall the birth stories of my older sister and me. My mom had natural deliveries with both of us, and she said it was excruciating, but she also said that once the baby came out, all of her pain disappeared and she felt happier than she ever felt before. Even though there can be scary situations, I think that fearing birth takes away from the experience. Women are meant for this, and with the proper support system, I believe that natural births are superior to medicalized births.

The current maternity care system attempts to treat every birth the same, which is homogenizing the way birth is thought about and handled. If birth is to be preserved as a natural

occurring event that is supposed to happen spontaneously, then birth advocates need to focus on denormalizing hospital births and mainstreaming homebirths. The Western approach to birth with its high frequencies of interventions like C-sections, needs to be challenged and countered. When unnatural, harmful, and impersonal procedures and processes are allowed, we stray farther from the natural event. With exposure to the lived realities of women and their babies who experience safe and fulfilling homebirth experiences, more people in the country may be able to re-shape their habitus and recognize alternatives to dominant medical structures in birth. While hospital births are becoming denormalized, we simultaneously need to normalize homebirths. This can happen through the dissemination of homebirth stories and facts about safety. Sara, who lived majority of her life in New Zealand is still getting accustomed to the way people in the United States "compete to tell the most horrific story about birth." She doesn't understand why women here are, "treated like they have something wrong." To Sara, "women in this country need to take back control over their bodies and their birth."

CHAPTER VI

CONCLUSION

I was nineteen the first time I questioned the maternity care system of the United States. It was during the end of my sophomore year at the University of Wisconsin-La Crosse, and I had to write a report on an anthropologist of my choosing. I knew I wanted to write about someone I hadn't learned about in class, and I sought the advice of my advisor. She handed me *Birth as an American Rite of Passage* by Robbie E. Davis-Floyd. The first pages sucked me in, and flipped the world I had previously accepted as normal and safe on its head. Davis-Floyd asks, "How is it possible that a medical specialty that purports to be scientific can appear to be so irrational?" (Davis-Floyd 2003:2). She uses the book to critique certain practices, like taking babies away from mothers after birth, to show how obstetric practices are "ritual responses to our technocratic society's extreme fear of the natural process on which is still depends for its continued existence" (Davis-Floyd 2003:2). I remember sitting, speechless, as I tried to comprehend everything that was discussed by Davis-Floyd. How had I never questioned the practices of hospitals before? Why do these practices continue when they aren't needed? And why, above all, would I allow the hospital to control my birth experience? I desired more knowledge about the maternity care system in the United States, and more information about why I and other women are socialized to prefer hospitals to homes.

From that moment in my undergraduate career, I knew I wanted to study birth. Exposure to a new way of thinking led me to question hospitals, insurance coverage, the power of the media, and gender relations, and how they shaped birth and the birth experience. I did not blindly accept homebirths, but I did begin to rethink birth in my culture. As my research for this thesis continued, I identified more questions. Evidence from the CDC and the American College of

Nurse Midwives supports the benefits of natural deliveries and homebirths, but they are uncommon in this country. Why are women reluctant to birth babies at home if it proven to be as safe as a hospital for most pregnancies?

Although this research is not representative of all women, it became clear to me the significant role of birth and birth experience stories. The stories people hear appear to be the most powerful factor when women make decisions about birth. Especially for women who have never given birth before, including me, the stories they hear help them get more comfortable with the unknown. Unfortunately, many birth stories that are portrayed on television or are told in person tend to be scary, negative, and full of pain. Perhaps these types of portrayals and stories dominate our society because we live in a society that is fearful.

Bringing about change to the maternity care system in the United States will not happen overnight, however, I am hopeful that it will happen. The notion that our approach is superior does "not allow for much tampering with the system," but looking outside of "American obstetrics at unmedicalized birthing systems within American culture" will help generate alternatives (Jordan 1993:145). Hospital births will be denormailzed when there is greater access to information about alternative birthing locations and partners are educated to be more receptive and less controlling. Positive stories need to be told from the women who have had successful births with no interventions. Based on the responses from the interviews in this study, hearing about other women who had positive births with little to no interventions was empowering to women. Women began to view their bodies as being capable instead on incapable, and the whole process shifted from being a medical event, to a normal life event.

One of the ways change will occur is when more women hear about the options outside of the hospital, and when they begin to know people who have had births at home or at a birth

center. This story sharing will create a snowball movement; as stories are told, the snowball will grow, gain momentum, and reach more people. Not only will spreading stories expose people to a new way of thinking about birth, but it will also address some of the fears they have. Fear and self-doubt will hopefully be outweighed by motivating and empowering stories of women trusting their bodies and not fearing birth.

REFERENCES

Ahearn, Laura M.
2001 "Language and Agency," in *Annual Reviews*, Vol. 30, pp: 109-137.

Bennett, Penelope
2011 Making the Choice: Cesarean Delivery by Maternal Request versus Planned Vaginal Birth.

Block, Jennifer
2007 Pushed: The Painful Truth about Childbirth and Modern Maternity Care, Da Capo Press, Cambridge, Massachusetts.

Boucher, Debora, Catherine Bennett, Barbara McFarlin, and Rixa Freeze
2009 "Staying Home to Give Birth: Why Women in the United States Choose Homebirth," in *Journal of Midwifery and Women's Health*, pp: 119-125.

Bourdieu, Pierre
2001 Structures, Habitus, and Practices. Readings for a History of Anthropological Theory, edited by Paul A. Erickson and Liam D. Murphy, Broadview Press.

Collins, Patricia Hill
1993 "Toward a New Vision: Race, Class, and Gender as Categories of Analysis and Connection," in *Race, Sex, & Class*, Vol. 1, No. 1, pp: 26-45.

Davis-Floyd, Robbie E.
2003 Birth as an American Rite of Passage, Second Edition. University of California Press, Berkley.

Declercq, Eugene R., Carol Sakala, Maureen P. Corry, and Sandra Applebaum
2006 *Listening to Mothers II*. Childbirth Connection, New York, NY.

Dempkowski, Alfreda
1982 "Future Prospects of Nurse Midwifery in the United States," in *Journal of Nurse-Midwifery*, Vol. 27, No.2, pp: 9-15.

Einhorn, Hillel J., and Robin M. Hogarth
1981 "Behavioral Decision Theory: Processes of Judgment and Choice," in *Journal of Accounting Research*, Vol. 19, No.1, pp: 1-31.

Goodman, Steffie
2007 "Piercing the veil: The marginalization of midwifes in the United States," in *Social Science and Medicine*, Vol. 65, pp: 610-621.

Grzywacz, Joseph G. and Juliana Fuqua
2000 "The Social Ecology of Health: Leverage Points and Linkages," in *Behavioral Medicine,* Vol. 26, No.3, pp: 101-115.

Janssen, Patricia A., Lee Saxell, Lesley A. Page, Michael C. Klein, Robert M. Liston, and Shoo K. Lee
2009 "Outcomes of planned homebirth with registered midwife versus planned hospital birth with midwife or physician," in *Canadian Medical Association Journal*, pp: 377-383.

Johnson, Kenneth C., and Betty-Anne Daviss
2005 "Outcomes of planned homebirths with certified professional midwives: large prospective study in North America," in *British Medical Journal* Vol.330, pp: 1-7.

Jordan, Brigitte
1993 Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States, Fourth edition, Waveland Press, Long Grove, Illinois.

Lindgren, Helena E., Ingela J. Radestad, Kyllike Christensson, and Ingregerd M. Hildingsson
2008 "Outcome of planned homebirths compared to hospital births in Sweden between 1992 and 2004. A population-based register study", in *Acta Obstetricia et Gynecologica,* Vol. 87, pp: 751-759.

Lusero, Indra
2010 "How Medicine and the Law (Almost) Killed Natural Birth in Colorado and What to Do About It."

MacDorman, Marian F., and Fay Menacker
2010 "Trends and Characteristics of Home and Other Out-of-Hospital Births in the United States, 1990-2006," *National Vital Statistics Reports,* Vol. 58, No.11, pp: 1-15.

Malloy, MH
2010 "Infant Outcome of Certified Nurse Midwife Attended homebirths: United States 2000 to 2004," in *Journal of Perinatology,* Vol. 30, pp: 622-627.

Martin, Joyce A., Brady E. Hamilton, Stephanie J. Ventura, Michelle J.K. Osterman, Sharon Kirmeyer, T.J. Matthews, and Elizabeth Wilson
2011 "Births: Final Data for 2009," *National Vital Statistics Reports,* Vol. 60, No.1, pp: 1-72.

Sakala, Carol and Maureen P. Corry
2008 "Evidence-Based Maternity Care: What it is and What it Can Achieve," Childbirth Connection, New York, NY.

Starr, Paul
1982 The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry, Basic Books.

Thorogood, Nicki and Judith Green
2009 Qualitative Methods for Health Research. Sage Publications Ltd.

Trotter, Robert T. and Jean J. Schensul
1998 Methods in Applied Anthropology. Handbook of Methods in Cultural Anthropology, edited by H. Russell Bernard. AltaMira Press.

Wagner, Marsden
2006 Born in the USA: How a Broken Maternity System must be Fixed to put Women and Children First. University of California Press, Berkley.

Yankauer, Alfred
1983 "The Valley of the Shadow of Birth", in *American Journal of Public Health*, Vol. 73, No. 6, pp: 635-637.

Zeidenstein, Laura
2000 "Birth of a Midwife," in *Journal of Midwifery and Women's Health*, Vol. 45, No.2, pp: 85-86.

American College of Nurse Midwives 2010
http://www.midwife.org/Become-a-Midwife. Accessed November 14, 2012.

American Hospital Association
http://www.aha.org/. Accessed March 31, 2013.

Colorado Hospital Association 2013
http://www.cha.com/CHA/Home/CHA/Default.aspx. Accessed March 31, 2013.

World Health Organization 2012
http://www.who.int/features/factfiles/maternal_health/en/index.html. Accessed November 16, 2012.

APPENDIX A

QUESTION GUIDE

Date:
Principal Investigator: Lauren Easton
POI # 241654

Face Sheet
1.) Age_____
2.) Gender_____
3.) Ethnicity_____
4.) How far along is pregnancy?_____
5.) What pregnancy is this for you?_____
6.) Last year of school completed_____
7.) Source of income_____
8.) What city do you live in?_____
9.) How far away is your doctor/midwife_____(miles)

Interview Questions

1.) Can you tell me about your pregnancy?
- Planned/unplanned

2.) Are you receiving prenatal care?
- Where?
- How did you choose it?

3.) Can you describe a typical visit with your birth attendant to me?

4.) Have you decided on a method of delivery?
- How did you decide?
- What did you birth attendant suggest?
- What does your partner think?

5.) Could you describe your ideal birthing experience to me?

6.) Can you tell me about your mother's birth experience?

7.) Do you know approximately how much money your birth will cost?
- Do you know how much your insurance will cover?

8.) How do you feel about hospitals?

9.) Do you expect to get an epidural?

10.) What is your opinion on C-sections?

11.) Do you know anyone who has used a midwife?
- What do you think about that?

APPENDIX B

RECRUITMENT FLYER

BE PART OF A RESEARCH STUDY ON BIRTH PRACTICES IN COLORADO

- Are you between 18-40 years of age?
- Are you currently pregnant or the partner of someone pregnant?
- Would you like to share your experiences with making important decisions about your pregnancy?

If you answered **YES** to these questions, you may be eligible to participate in the research study **DELIVERY AND BIRTH ATTENDANT DECISION MAKING PROCESS AMONG PREGNANT WOMEN**.

The purpose of this study is to better understand the decision making process of pregnant women and their partners when choosing a birth attendant and method of delivery. We are looking for pregnant women and/or their partners to give interviews about their decisions and opinions about their choice in birth attendant and delivery method.

This study is being conducted by a graduate student at the University of Colorado-Denver. If you would like to participate, or would like more information please contact Lauren Easton by phone at **(720) 300-1847** or email at **LAUREN.EASTON@UCDENVER.EDU.**

COMIRB # 12-1646